(personal communication, Tosti A, March 1997). One should be careful to distinguish relapse from reinfection when discussing recurrence of disease. Recurrence of onychomycosis beyond a certain time point after stopping antifungal therapy (e.g., 1 1/2 years) is more likely to be caused by reinfection. Thus, it is important to educate the patient to take measures that will reduce reinfection with onychomycosis.

The authors are investigators and consultants to Pfizer, Janssen, and Novartis and as such often are asked to lecture for these companies. A conflict of interest declaration was submitted with our article. One of the authors (PDD) is employed by Janssen, as is published in the article.

In the majority of cases, onychomycosis is treated for noncosmetic reasons. In a sizeable proportion of patients this disease is associated with discomfort, pain, difficulty in wearing appropriate footwear and in walking, and the inability to perform activities of daily living to the maximum potential.[8] Onychomycosis, especially fingernail disease, can have an important impact on psychological well-being. Both family members and strangers may avoid contact with an individual with abnormal-looking nails for fear of becoming infected themselves. Fingernail onychomycosis in particular can interfere with the ability to perform certain tasks such as typing and playing musical instruments. Tinca pedis is often associated with onychomycosis and these may predispose to cellulitis, thrombophlebitis, urticaria, and hypersensitivity symptoms due to *Trichophyton* allergens and molds. In individuals with a sufficiently depressed immune system, systemic dissemination of fungal infection can take place.[6]

In regard to the benefit-risk ratio of the newer antifungal agents, with careful patient selection and counseling, data show that itraconazole, terbinafine, and fluconazole have a high benefit-to-risk ratio in the treatment of onychomycosis.[9]

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CORRECTION

In Dr Julie Madorsky's article in the June 1997 issue,[1] there is an editing error that changed the meaning of one of the author's points. In the editing process, in paragraph 2, the word "might" was inserted in the sentence, "... many of Dr Jack Kevorkian's assisted suicide cases [might] have had disabilities?" The corrected sentence should read as follows: "Might there be a connection between the beliefs about the perceived invalidity of persons with disabilities and the fact that, in addition to individuals with terminal illnesses, many of Dr Jack Kevorkian's assisted suicide patients had disabilities?"

"It is a fact," writes Dr Madorsky, "that several of Dr Kevorkian's clients were individuals who did not have a terminal disease, but who had physical disabilities such as multiple sclerosis. That was the point of my Commentary. It is one thing to assist the process of death in a person who has a terminal illness that is going to result in death within six months or less. It is an entirely different matter to cause death in a person who does not have a terminal condition, but a disabling condition."

The Editors

REFERENCE

1. Madorsky JG. Is the slippery slope steeper for people with disabilities? West J Med 1997 June; 166:410–411

CORRECTION

In Dr Arthur Rivin's article in the June 1997 issue,[1] there is an editing error in the two bulleted items on page 393. They should read as follows:

- A family conference with the entire ethics committee is cumbersome and sometimes intimidating; a smaller group of ethics committee members should represent the committee. Communication skills in those circumstances need to be taught.
- Care providers other than the attending physician need to have access to the bioethics committee.

The Editors

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1. Rivin AU. Futile care policy: lessons learned from three years' experience in a community hospital. West J Med 1997 June; 166:389-393